Children's Hospital devising plan to move tiniest, most critical patients

By Karen Robinson
Mon, Apr 3, 2017
Buffalo News

When November comes, so does the big move of potentially up to 64 tiny, intensive care babies to the new John R. Oishei Children's Hospital.

Dr. Anne Marie Reynolds is right in the thick of it, helping to fine-tune every intricate detail of the largest unit to move from Women & Children's Hospital of Buffalo to its new home on the Buffalo Niagara Medical Campus.

Reynolds oversees the hospital's neonatal intensive care unit, which will transfer the most medically fragile babies to the new, $270 million hospital, plus handle any new births of premature infants that begin occurring that same day at the new facility at 818 Ellicott St.

The unit specializing in care of those babies will move into new digs the size of a football field on the fourth floor of the new hospital.

Reynolds is medical director of the hospital's neonatal intensive care unit and associate chief for the division of neonatology.

**Q: Moving the neonatal intensive care unit is a huge undertaking. What will be the easiest part of that move?**

A: We are very lucky to have a neonatal transport team that transports critically ill infants from all parts of Western New York every single day. They are highly trained and highly skilled, and I have full confidence that they are going to be able to move our patients from Women & Children's to the new Oishei Children's Hospital efficiently and faithfully.

**Q: What could be the most difficult component of that move?**

A: From a physician's standpoint, we want to try to eliminate any moves that could put a patient at risk. The patients that are the highest risk to move are those that are the most premature. We really want to try to avoid having to move extremely premature babies if they don't have to be moved. We haven't made final arrangements to determine what we're going to do with those babies. But I think from our standpoint, we can do it if we absolutely have to. If a mom came to our doors and needed to deliver a premature baby, we could definitely handle it, but I think we don't want to take risks that we don't have to take.

I'm talking about 23/24-week gestational-age babies. We might look at a period of time maybe three or four days before the move, and moms that we can divert to another hospital, potentially might be diverted to avoid having to move. ...
It's just for the safety of our patients. Why put someone at risk if they don't absolutely have to be at risk? That's kind of the hardest decision for us to make. We are most equipped to deal with the extreme-term infant that has problems – all of those babies compared to other NIC units in the area. It's a difficult decision to make. It has not been made yet. We're ironing it out.

**Q:** Let's say you have a baby born six days before the move and it's very, very tiny. Would you still be looking to move them?

A: Most of the time we know ahead of time if moms are referred from other places that they're likely to deliver here. For those moms that are very, very likely to deliver and they have an extremely premature baby, we may, may, send that mom to another hospital so that this baby is not going to have to move on Day 2 of life if we can avoid it. But for babies that are bigger, for babies that have been born and are now four or five days old, those kids are much less risky to move.

**Q:** All babies will be moved by ambulance. How long will it take to move each baby?

A: It depends on how sick the babies are and how much support they need going over. But for babies that are generally pretty stable, only about 20 minutes per baby, and a little bit longer for those that require more support. And that's from the time they're leaving our NIC unit going down to the first floor, getting onto the ambulance, driving over, getting them off the ambulance and up to the fourth floor.

**Q:** Are you bringing on any additional staff to handle this that particular day?

A: Yes. It's not staff that is not our own, but it's more staff than we would typically have on one day. It's still being worked out. The number of staff from a nursing standpoint, we'll probably be at least 50 to 75 percent more staff that day because we will have full staff here, and then we'll have a group of staff that's already over at Oishei if there were deliveries that were occurring there right away as we open up, and to start accepting the patients as we transfer them over. I would say we'll have three times as many people for the transport team than we would typically have. We'll have one team designated still to respond to any transports that need to happen from the community. We'll have a team at Oishei in the morning ready to attend deliveries should they have high-risk deliveries. Then, two or three teams available to move the babies over.

We also are looking at trying to manage that number ahead of time. We may say this delivery, when we can control it, would be better done at another hospital. We have Millard Fillmore Suburban and a NIC that we also manage and provide care for those infants there. We can say any mom over 32 weeks gestation can deliver at Suburban probably in the week before to try to manage our census over here.

**Q:** How many babies do you typically have in this unit at one time?

A: Our average daily census is around 51. We have a 64-bed capacity. We've definitely been at 64, and we're hoping we're not there on the day of the move. But we can handle it if we have to.

**Q:** How are you addressing concerns of parents?
A: Making sure that we have excellent communication with the families because it's probably very anxiety-inducing to be a parent and know that we're going to be moving your baby to a new hospital. We are very well-equipped to do it. It's just helping the families to understand. We have a plan for each family to have a liaison – either an attending physician or a fellow who is a board-certified pediatrician doing extra training in neonatology. They will be assigned to probably five families and they're responsible for all the communication to those families about what to expect that day, about what time we think the baby is going to be going and then updates on how things went.

Q: What will be different about the neonatal unit over at Oishei?

A: It will be single bed, individual patient rooms in NIC Unit. Not a pod. It's a beautiful new unit which is kind of the philosophy that everyone in the country has been going to, where each patient is in their individual room and there's more space for the family there, and space if the family wants to stay overnight.

Q: How are things progressing now for this unit at Oishei? Is it already pretty much done?

A: The unit will be the same capacity based on the projected population of Buffalo. There are lots of things still to go up in there. I was there last week and was able to look around and get to see how things are shaping up. It's the fourth floor of the new hospital and our unit is the size of a football field just for 64 babies. Because 64 beds and the size of a football field sounds overwhelming, it's going to be divided into four different neighborhoods.

One is kind of a family care neighborhood where there's space for families to sit down, relax, lockers, bathroom facilities and laundry facilities. The other three neighborhoods are patient care areas and they are kind of self-contained. Each one of the little neighborhoods will have nurses designated for those areas, physicians designated for those areas, supply rooms, supporting each one of those areas to try to make it a little more cozy for everyone.